CLAUDE FAMILY MEDICAL CLINIC

Patient Information

Name_____Date_____

Address_____

City_____State_____Zip Code_____

Date of Birth_____SS#_____

Male_____Female_____ Married_____Single_____

Home Phone #_____Work/Mobile Phone #_____

Employer_____Occupation_____

Parent/Spouse_____Parent/Spouse Employer_____

Parent/Spouse Mobile #_____Work #_____

Emergency Contact Name _____ Phone #_____

Driver's License Number _____ State_____

Insurance Information: *copy of current insurance card required*

Insured Name_____SS #_____

Date of Birth_____Relationship_____

Employer_____

Group #_____ ID #_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependants and that I will be bound by this signature as though the undersigned had personally signed each particular claim.

I_____ hereby authorize my insurance carrier to pay and hereby assign directly to CLAUDE FAMILY MEDICAL CLINIC all benefits if any other wise payable to me for services. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received by and paid to CLAUDE FAMILY MEDICAL CLINIC will be credited to my account in accordance with the above assignment.